**Eastern Plains Medical Clinic of Calhan**
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# HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record. **If more space is needed please use a separate piece of paper.**

| | |
|---|---|
| **Name** *(Last, First, M.I.):* ☐ M ☐ F | **DOB:** |
| **Do you have an Advanced Directive?** DNR? MOST form? Etc. | **Yes** **No** **Unknown** |

| **PERSONAL HEALTH HISTORY** | | |
|---|---|---|
| **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** | | |
| Name the Drug | Strength | Frequency Taken |
| | | |
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| | | |
| **Significant past medical history:** | | |
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| | | |
| | | |
| **Allergies to medications** | | |
| Name the Drug | Reaction You Had | |
| | | |
| | | |
| | | |
| | | |
| **Surgeries** | | |
| Year | Reason | Hospital |
| | | |
| | | |
| | | |
| | | |
| | | |

| Other hospitalizations | | |
|---|---|---|
| Year | Reason | Hospital |
| | | |
| | | |
| | | |

## FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|---|---|---|
| **Father** | | | **Children** | ☐ M ☐ F | |
| **Mother** | | | | ☐ M ☐ F | |
| **Sibling** | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | **Grandmother** *Maternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Maternal* | | |
| | ☐ M ☐ F | | **Grandmother** *Paternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Paternal* | | |

## HEALTH HABITS

| | | | | | |
|---|---|---|---|---|---|
| **Alcohol** | Do you drink alcohol? | | | ☐ Yes | ☐ No |
| | How many drinks per day? | | | | |
| **Tobacco** | Do you use tobacco? | | Vape? | ☐ Yes | ☐ No |
| | ☐ Cigarettes – pks./day | ☐ Chew - #/day | ☐ Pipe - #/day | ☐ Cigars - #/day | |
| | ☐ # of years | ☐ Or year quit | | | |
| | Have you considered stopping? | | | ☐ Yes | ☐ No |
| **Drugs** | Do you currently use recreational drugs or drugs not prescribed to you? If so, what? | | | ☐ Yes | ☐ No |
| | Have you ever given yourself street drugs with a needle? | | | ☐ Yes | ☐ No |

## PREVENTATIVE HEALTHCARE

| | | |
|---|---|---|
| **Immunizations and dates:** | ☐ Tetanus | ☐ Pneumonia |
| | ☐ Hepatitis | ☐ Varicella |
| | ☐ Influenza | ☐ MMR *Measles, Mumps, Rubella* |
| **Screening Tests and dates:** | ☐ Mammo | ☐ PSA (prostate) |
| | ☐ EKG | ☐ Colonoscopy |
| | ☐ Pap | ☐ Bone Density |
| | ☐ Cholesterol | ☐ Other Labs |